

Chapter 22

Hospice and Palliative Care: Options for Care at the End of Life

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Exhibit 22A. Hospitals, Hospice Agencies, and Others Offering Palliative Care

- “Hospice was great for my husband, but quite frankly, it saved my life.”
- “I’ve never met such caring people — they made a tough time almost a pleasure.”
- “Honestly, I think Mom lived longer with hospice than she would have without it!”

These are the kinds of comments we hear every day from people who have experienced hospice care. Ask around, and you are likely to hear the same. After all, in 2022 approximately half of Americans (47.3 percent) and Coloradans (49.0 percent) received hospice care when

they died.¹ According to Medicare’s Care Compare tool,² 90 percent of patients appreciated the emotional and spiritual support provided by hospice.

Even so, many people and their families who could benefit from hospice care don’t receive it — because they don’t know about it or have inaccurate ideas about it; because they don’t know it’s fully covered by Medicare Part A, Medicaid, and most private insurance plans; or because they wait too long and, in the crisis, don’t have the information they need.

What exactly is “hospice,” and how does it work? How is it paid for, and how can you get it? And what is “palliative care,” and how is it different from hospice? This chapter answers these questions and more.

22-1. What Is Hospice?

“Hospice” is not a place, like a nursing home or hospital. It is a way of caring for persons with terminal, or “end-stage,” illness and supporting their families, provided by a specially trained team of professionals. The team works together and with the patient and family to maximize comfort and quality of life. The hospice approach emphasizes care for the whole person: body, mind, feelings, spirit, and relationships. In hospice, you are not “the gallbladder in Room 232,” but a person with a history, complex and important feelings, goals and dreams, family and friends — and, by the way, an advanced illness.

Most hospice patients receive care in whatever setting they call home. This includes nursing homes and assisted living residences. The idea is to maintain independence, familiar surroundings, and meaningful relationships for as long as possible. Hospice is not focused on curing the disease, but easing its distressing effects: pain, fatigue, nausea, dry mouth and skin, breathing difficulty, anxiety, sleeplessness, depression, and so on.

Hospice care is just as “aggressive” as curative care. Vigorous attention and sophisticated treatments and medications are used to maintain quality of life and comfort. Many people enrolling in hospice experience a kind of “hospice bounce.” One study showed that, on average, persons enrolled in hospice *actually lived longer* — some by weeks — than persons with the same diagnoses receiving curative treatment.³ And — like comic columnist Art Buchwald — about 15 percent of persons enrolled in hospice actually “graduate” and are discharged alive,⁴ in many cases because their condition has so improved, they are no longer considered “terminal.”

¹ Hospice Analytics analysis of Medicare Hospice claims, private communication (March 11, 2024).

² www.medicare.gov/care-compare/, per Hospice Compare 2023 Q4 results.

³ S.R. Connor et al., “Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window,” 33 *J. Pain Symptom Mgmt.* 238 (March 2007), www.ncbi.nlm.nih.gov/pubmed/17349493; J.S. Temel et al., “Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer,” 363 *New Eng. J. Med.* 733 (Aug. 2010), www.nejm.org/doi/full/10.1056/NEJMoa1000678.

⁴ Medicare Payment Advisory Commission (MedPAC) March 2022 Report to the Congress: Medicare Payment Policy, p. 385, <http://www.medpac.gov/-documents-/reports/>.

22-2. How Can I Get Hospice Care?

Enrollment Criteria

In order to enroll in hospice, you must have a “terminal” illness and a life expectancy of six months or less, as certified by two physicians. This means that your attending or primary physician or any specialist involved in your care and a hospice medical director say that in their best professional judgment, your illness, if allowed to proceed without intervention, is likely to result in your death within six months. You must also agree to forego treatments that are intended for cure and not for comfort.

Note: The enrollment criteria and other information about duration of care and coverage of costs in this chapter are specific to the Medicare Hospice Benefit. If you are covered by private insurance, criteria may differ. Be sure to check with the insurance agent or ask the hospice social worker to confirm your coverage.

If you do not have a primary or attending physician or encounter resistance to a hospice referral, you can still request an evaluation directly from a hospice agency. The hospice medical director can, in some circumstances, certify your eligibility for hospice care.

Also, many hospices have “open access” policies that offer a great deal of flexibility to allow and cover treatments that have traditionally been considered curative but can be “palliative” — that is, increase comfort or relieve pain. For instance, a hospice patient might receive “palliative radiation” to reduce the size of a tumor that is pressing on his or her spine in order to relieve pain or prevent paralysis.

Many hospices are now working to provide earlier access to hospice services by providing pre-hospice palliative care or transition programs. These programs allow patients and families to receive some of the services and symptom-management benefits of hospice care without formal hospice enrollment. Palliative care is discussed in more depth in the second half of this chapter.

Duration of Care

Once you are enrolled in hospice, your condition is closely monitored. If your condition is progressing as expected, you may stay enrolled in hospice as long as needed. Initial coverage extends for 90 days from enrollment, at the end of which your condition and eligibility are assessed. If you continue to be eligible for care, your situation is assessed again after another 90 days and then after each additional 60 days. Your enrollment is “recertified” as long as the basic hospice criteria are met — even long past six months. Sadly, less than 15 percent of hospice patients receive a full six months of care or more.⁵ Currently, half of all hospice patients are enrolled for just over three weeks before death, more than a quarter for less than a week, and some only for hours.⁶ This is not long enough to obtain the full benefit of the program of care, and many, many families find themselves saying, “I wish we’d gotten into hospice sooner!”

Note: Hospice enrollment is not a one-way street. If you don’t like hospice care, wish to resume curative treatments, or get better, you can check out of hospice care (or “revoke”) at any time. As long as criteria are met, you may also re-enroll.

⁵ Hospice Analytics analysis of Medicare Hospice claims, private communication (March 11, 2024).

⁶ *Id.*

Getting a Referral to Hospice

There are many paths to hospice care. Each person's circumstances are unique. In general, however, the starting point for hospice care is the recognition that your illness cannot be cured or effectively managed. This may be a new diagnosis, coming as a shock after a brief period of illness or mildly worrisome symptoms. Or it could be a further development of an illness that has been controlled but not getting any better for some months or years. Or it could be that the disease has just outpaced available treatments. Most people these days do not die of classically "terminal" illnesses; rather, they suffer from long-standing chronic illnesses, sometimes several at once, that just gradually get worse over an unpredictable period of time.

This can make it difficult to get a hospice referral at the right time. Doctors may resist stating clearly that an illness has reached this "terminal" phase, or "end stage." In today's health care world, it seems there is always something more to try in search of a cure, and doctors are rightly committed to their patients' survival. However, even when an illness is clearly terminal, doctors can be very reluctant to answer the question, "How long do you think Mom has?" Honestly, they just don't know. An important research study showed that when asked to make predictions about their patients' likely survival time, doctors typically *overestimated* by a factor of 5; that means they thought, in all good faith, that their patients would live 5 times longer than they actually did. And the better the doctor knew the patient, the more he or she overestimated.⁷

Tip: If you have any question about whether hospice might be the right choice for you or your loved one, here's a good way to ask the question: "Would you be surprised if (Mom) were alive in a year?" If the answer is yes, a good follow-up question would be, "Would hospice be a good option for (Mom) now?" If the answer is yes, or even maybe, you now have a hospice referral.

If your illness has reached this stage, and if your own doctor is resisting the idea of hospice for whatever reason, you can ask for an evaluation by a hospice doctor or nurse as a first step. This evaluation can be done in the hospital, nursing home, or at home.

22-3. How Does Hospice Work?

During the evaluation or admissions interview, the doctor or nurse can explain how hospice works. Here's an outline:

The Hospice Care Team

Hospice care is provided by a team of professionals:

A *physician*, who supervises the care, meeting regularly with the other members of the team to discuss the care plan and how things are going. Visits from the physician are likely to be infrequent, but he or she is closely monitoring your care and available for consultation at any time.

⁷ N.A. Christakis & E.B. Lamont, "Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients: Prospective Cohort Study," 320 *BMJ* 469 (Feb. 2000), www.ncbi.nlm.nih.gov/pmc/articles/PMC27288/.

Note: You don't have to give up your current doctor when you enter hospice. He or she can continue to supervise your care along with the hospice team. However, hospice doctors are specially trained in pain and symptom management and may have skills and "tools" other doctors lack.

A registered nurse, who visits you regularly, supervises the nurse's aide, and reports to the doctor and other team members. Just how often the nurse visits will depend on a lot of factors, but typically it's once or twice a week. The nurse, in consultation with the doctor, will work to relieve pain and other symptoms, including nausea, anxiety and depression, fatigue, shortness of breath, skin irritations, problems with bowel and bladder function, and so on. Nurses keep a close eye on your mental and emotional health as well and will alert other team members if difficulties arise.

A certified nursing assistant, who provides help with personal care, if needed. This includes bathing, dressing, hygiene, light food preparation (snacks), and so on.

A social worker, who can address social, emotional, practical, and financial challenges. For instance, social workers can help organize extra caregiving help; complete important financial or practical preparations for death; mediate family disputes; interpret insurance policies and obtain benefits; or provide support to your spouse or life partner, children, or other family members in distress.

A chaplain, who is specially trained to respond to the spiritual aspect of facing advanced illness and the end of life. While chaplains may be ordained in or members of a particular religious tradition, they do not preach or promote any particular belief or faith. More than anything, they are expert listeners.

A volunteer, who can spend a few hours a week with you to give your family a break, do errands or laundry, prepare light meals, help with projects or tasks, or just visit.

Other specialists such as physical therapists or dieticians may be included, if needed. Some hospices even offer pet, aroma-, music, art, or massage therapy. All hospices have team members available 24 hours a day, seven days a week, 52 weeks of the year. Help is only a phone call away at any time of the day or night.

Note: The nurse and certified nursing assistant (CNA) will probably be the most frequent visitors. In fact, the nurse is the only team member that you must consent to see. The services of all the other team members are entirely optional and scheduled only as needed or desired. Everything is carefully tailored to individual needs and desires.

Hospice Care at Home and Other Options

As previously noted, most hospice care is delivered to the person at home, including nursing homes and assisted living residences (ALRs). If or when a person cannot remain at home, the hospice can arrange a care-facility placement — typically a nursing home — and continue to provide care there. For these patients and for long-time nursing home residents needing hospice care, the nursing home staff and the hospice team work together to coordinate the best combination of skilled nursing and hospice care. Likewise, hospices offer brief "respite stays" in care facilities for patients to give family caregivers a break or if they must go out of town or become ill themselves. Some hospices have dedicated, stand-alone residences to provide this inpatient care. Nationally, about 15 percent of hospices have their own inpatient residences. In

Colorado, only nine of the 75 hospices (serving from 106 locations) have inpatient residences: three in the Denver metro area and one each in Boulder, Colorado Springs, Fort Collins, Grand Junction, Greeley, and Pueblo.⁸

Hospice Care for the Family

Hospice considers the patient *and the family* to be under their care: all immediate family members, companions/life partners, and caregivers may ask for and receive attention and advice from members of the team. Family members are offered free grief counseling and bereavement care for up to 13 months after the patient's death. Many hospice agencies also offer grief education and support groups to the wider community.

Note: While all hospices must offer some form of bereavement support, programs vary widely. Some hospices call or send periodic letters or newsletters; others offer group support meetings or individual counseling. Some offer educational programs on various aspects of grief, bereavement, and coping. A few offer special programs for children and teenagers, including summer camps. If grief support will be important to you or your family, be sure to ask about these services when you are making your choice of hospice.

Quality of Hospice Care

The hospice field has grown tremendously since 2000. Between 2000 and 2022, the number of hospice agencies has increased by 132 percent, and the number of patients served has more than tripled.⁹

In 2022, more than 1.7 million Medicare beneficiaries were cared for by 5,800 hospices.¹⁰ In many ways, this growth is a good thing, signaling broader acceptance of the hospice model and increased access to services for more patients and families. However, growth has also created some concerns about quality and standards. For complicated historical reasons, hospice care has not been subject to the same level of supervision and consumer critique that other sectors of health care have experienced. However, with recent crackdowns on waste, fraud, and abuse in health care generally, along with increasing emphasis on quality and outcomes, hospice is attracting much closer attention. The vast majority of hospices are providing excellent care with the best interests of patients, families, and communities at heart, but some cautions are worth noting.

Quality Indicators and Consumer Information. Agencies are now asked to collect and report to regulators a certain set of quality measures, which will be used to offer comparative information to the public. In order to help patients and family make informed decisions, the Centers for Medicare and Medicaid Services launched Care Compare (including Hospice Compare),¹¹ a website that includes seven categories of data about approximately 6,000 hospices around the country. Categories include percentages of successful patient/family education and support around critical issues such as pain assessments and symptom management. Some

⁸ Hospice Analytics' National Hospice Locator, www.NationalHospiceLocator.com.

⁹ Hospice Analytics analysis of Medicare Hospice claims, private communication (March 11, 2024); Medicare Payment Advisory Commission (MedPAC) March 2023 Report to the Congress, *supra* n. 4.

¹⁰ *Id.*

¹¹ Care Compare, www.medicare.gov/care-compare/.

information is reported directly by the hospice, while other information is reported by family members about six months following the death of a loved one. Hospice Compare continues to evolve to better address public concerns and questions.

Many state and national hospice organizations offer hospice provider directories so consumers can locate agencies, but most do not provide much information beyond hospice name, location, service area, and maybe areas of specialty. However, the National Hospice Locator,¹² hosted by Hospice Analytics, is a database of every known hospice in the country, now sorted by an internal quality algorithm, including abundant comparative criteria about services and some quality measures.

Certification and Accreditation. All hospices must be licensed by the state and adhere to state regulations for health care facilities. Licensure in Colorado requires an application and “attestation” that the hospice meets the state regulations for operation. Hospices must be certified by Medicare or accredited by a Medicare-approved organization (e.g., Community Health Accreditation Partner,¹³ Joint Commission,¹⁴ or Accreditation Commission for Health Care¹⁵) in order to receive payment from Medicare for services to Medicare beneficiaries. Certification or accreditation requires a survey, conducted either by the state health department or the accrediting organization, to ensure that the hospice is operating according to the Medicare standards and state regulations. Certification ensures that the agency is meeting minimum standards; accreditation often requires a higher standard of performance.

Hospices without a license cannot legally serve patients. An operating hospice that is licensed but not certified or accredited, however, requires closer scrutiny. It is possible that the hospice is very new. In order to be certified or accredited, the hospice must be serving at least a few patients at the time of survey in order to demonstrate competencies. Care from a brand-new hospice may be excellent, even superior, or it may be deficient. Before enrolling in an uncertified hospice, ask a lot of questions and make sure you are satisfied with the answers (see “Locating and Evaluating a Hospice” in section 22-5). Volunteer or government-owned hospices (such as prison hospices or those operated by states, cities, or counties) might not be certified because they do not receive payment from Medicare. Again, caution is advised.

Surveys and Deficiencies. Hospices, like all health care facilities, are subject to periodic surveys in order to retain their certification or in response to a complaint. Hospices are required to be surveyed for Medicare compliance at least every three years. Complaint surveys may occur at any time.

When hospices are surveyed, any problem or failure to meet regulations is termed a “deficiency.” Deficiencies can be very minor or have no impact on patient care (e.g., unclear documentation or lightbulbs of the wrong wattage) or very serious indeed (e.g., medication errors or failure to respond to a pain crisis). A perfect survey is very rare; almost every survey turns up a few deficiencies. The raw number of deficiencies incurred by a hospice does not, by itself, tell much about the hospice’s quality of patient care. What matters is the seriousness of the deficiencies and how well they have been corrected. Survey results, deficiencies, and plans of

¹² Hospice Analytics’ National Hospice Locator, www.NationalHospiceLocator.com.

¹³ Community Health Accreditation Partner, <https://chapinc.org>.

¹⁴ The Joint Commission, www.jointcommission.org.

¹⁵ Accreditation Commission for Health Care, www.achc.org.

correction are available online from the Colorado Department of Public Health and Environment once the case has been closed.¹⁶

Fraud and Abuse in Hospice. It's a terrible thing and many hospice professionals are uncomfortable admitting it, but hospice is not exempt from fraud and abuse. Fraudulent practices include admitting patients who are not eligible (*e.g.*, their condition is not terminal) or who do not understand they are signing up for comfort care only; keeping patients on service when they no longer meet strict criteria; bumping patients up to a more intensive level of care (for which the hospice is paid a higher amount); "cherry picking" patients according to diagnosis in order to minimize expense or maximize profitability; or providing extra services or equipment to nursing facilities in order to gain preference in referrals. Patient abuse can result from promising services the agency can't deliver; maintaining patients on a routine level of care when they require more intensive interventions; not providing adequate after-hours or weekend/holiday coverage; providing inadequate screening, training, or supervision to clinical personnel resulting in harm to patients; or misusing potent medications.

While occurrences of these kinds have been reported, fortunately they are rare. *A small percentage of hospices are identifiably practicing outside the norms* in a way that signals possible fraud. Cases of patient harm are harder to quantify, but are not common, despite occasional distressing stories in the media. Still, any occurrence is one too many, and numerous organizations in the industry are working closely with regulators to eliminate them.

Note: Much of the growth in hospice care since 2000 has been in for-profit hospices, and concerns have been raised by journalists and watchdog groups that the pressure to increase profits is at the root of problems in hospice care. Data does show that for-profit hospices, as a group, spend less on patient care, provide less of the more intensive levels of care, have a higher rate of discharge of live patients, and frequently keep patients on service much longer than typical. However, the for-profit/nonprofit status of a given agency is not, by itself, an indicator of quality. In Colorado, the only three hospices closed for reasons of fraud and abuse were for-profit agencies (one each in 1997, 2008, and 2016), although numerous for-profits across the state provide excellent care. Each hospice should be evaluated on its own merits, not its corporate tax status.

22-4. How Is Hospice Care Paid For?

Options for Coverage for Care

Hospice care is a fully covered Medicare Part A benefit for Medicare beneficiaries, and most private insurance plans have a comparable hospice benefit. If you or your family member are not covered by Medicare or private insurance, Medicaid also has a hospice benefit in Colorado and many other states. Also, many hospices have a commitment to provide care regardless of a person's ability to pay, supported by community fundraising, donations, and grants.

¹⁶ Colorado Department of Public Health & Environment, Hospice Consumer Resources, www.colorado.gov/pacific/cdphe/hospice-consumer-resources.

The Medicare Hospice Benefit

For persons receiving hospice care under Medicare, the Medicare Hospice Benefit covers all services of the team and all medications, equipment and supplies, and care related to the terminal illness. There may be a modest copay for some drugs. Items and services not related to the terminal illness remain your responsibility. For instance, if you are enrolled in hospice due to cancer and have a fall and break your hip, the costs of treating the broken hip will not be covered by the Hospice Benefit, but likely will be covered by other parts of Medicare or your private insurance plan.

In some cases, room and board — whether in a nursing home, hospice residence, or hospital — are covered by the Medicare Hospice Benefit or private insurance. In other cases, these costs must be paid by you. Just when room and board is covered depends on the level of care you are receiving and the reason for your stay in the facility. Even over the course of a single stay, some days might be covered and some not. Most rooms in stand-alone hospice residences are private; some hospices offer shared rooms to reduce costs. Rates vary depending on location and level of care, but they tend to range between \$700 and \$900 per day.

Prior to enrollment in hospice, it's a good idea to have a thorough conversation with the admissions nurse or social worker on financial matters. Ask questions and get clear answers from the individual hospice agency about what benefits apply, what they cover and don't cover, room and board rates and charges, and any other resources that might be available.

Note: If you or a loved one are a veteran of the United States Armed Forces or National Guard, be sure to ask about Veterans Administration benefits and services. There is good information on the VA website about their palliative care services and death and burial benefits. Go to www.va.gov/geriatrics.

22-5. How Can I Find Care and Choose a Hospice?

Hospice in Colorado

As of 2022, in Colorado, there were 75 hospice agencies providing care out of 106 locations and nearly 25,000 Coloradans received hospice care. Nine hospice agencies now have dedicated inpatient residences. Since 2015, the number of for-profit hospices has exceeded the number of nonprofit hospices in Colorado. A handful of hospices are run by the state or federal government.

About two-thirds of Colorado's hospices are in urban areas and about a third are in rural regions. In urban areas, there may be several hospices from which to choose, while some rural areas are served by one agency. In 2022, at least one person received care under the Medicare Hospice Benefit from each of Colorado's 64 counties. Each hospice organization has its own "flavor," admissions policies, and range of offerings beyond the core, mandated services.

Locating and Evaluating a Hospice

Just like any important decision in life, your choice of hospice should be made carefully, based on up-to-date and reliable information, and after several deep breaths. Your doctor, hospital, or nursing home may recommend a particular hospice, but unless you live in an area served by only one agency, you do have a choice. Your top concerns should be quality and a good "fit" between you and the hospice staff and style.

A good first step in locating a hospice is to ask around. Chances are good you will know friends, colleagues, neighbors, and others who have had a family member in hospice. Even with a glowing recommendation, though, it is good to look closer.

There are two comprehensive resources for locating hospices in your area: Hospice Analytics' National Hospice Locator¹⁷ and the Colorado Department of Public Health and Environment (CDPHE).¹⁸ The National Hospice Locator, now sorted using an internal quality algorithm, allows you to search by hospice, state, or zip code. You can compare agencies on several criteria: quality, ownership type (nonprofit, for-profit), agency type (free-standing, in a nursing facility, affiliated with a hospital), size (based on number of patients served daily), innovative or special services, inpatient unit, state and national organization memberships, accreditation, certification, and a set of utilization measures that can be used as indications of quality. The results provide contact information and direct links to agency websites. The CDPHE online directory lists all the hospices in the state and survey results but does not provide any comparative criteria. Be aware that hospices tend to serve several counties, so if you do not find a hospice with an office in your city or town, there may be one nearby that serves your area.

Note: Hospice programs are very sensitive to how racial, ethnic, cultural, and religious factors can influence a person's approach to death, funeral preferences, and the family's style of coping. Some agencies have gained special certifications in caring for members of particular cultural or religious communities; some have Spanish-speaking patient and family assistance or care teams and other non-English language interpreters; some have particular affinities with or historical ties to religious traditions. If these factors are important to you, be sure to ask about them when you talk to the hospice representative.

As noted earlier, hospice enrollment has some requirements, but a meeting with a hospice representative to get acquainted and discuss their services can be arranged at any time. If the hospice has a stand-alone residence, you may tour the facility. When you contact a hospice to discuss their services, here are some key questions you should ask:

► **Are you certified by Medicare and/or accredited?**

See "Quality of Hospice Care" in section 22-3 for comments regarding certification and accreditation. If the hospice is not certified or accredited, determine why and consider carefully whether this hospice is right for you.

► **How long have you been operating? Are you for-profit or nonprofit?**

Older hospices are likely to be better established and better resourced, with more history of patient experience and survey results. Newer hospices can still be very good but might require extra evaluation.

As noted, for-profit or nonprofit status does not, by itself, say anything about the quality of care the hospice provides, but it is an important feature to be aware of.

¹⁷ Hospice Analytics' National Hospice Locator, www.NationalHospiceLocator.com.

¹⁸ Colorado Department of Public Health & Environment, Hospice Consumer | Resources, www.colorado.gov/pacific/cdphe/hospice-consumer-resources.

► **What services do you provide?**

Services should match the description of hospice care provided in this chapter. Make sure social work, chaplain, and volunteer services are mentioned; they are important aspects of the hospice model even if you don't think you will need them. If it is important to you, ask if your doctor can stay involved in your care.

If you or your family member might benefit from specialty services — such as those designed for children/teens, veterans, or particular ethnic or cultural groups — be sure to ask specifically about these programs.

► **What are our options if I or my loved one can't stay at home, or our family needs a break?**

Every hospice should have an option to care for patients in a facility (nursing home or stand-alone residence) if home care is not possible. Likewise, respite care should be available to give families a break.

If you or your loved one already reside in a nursing home, ensure the hospice can provide care in that facility. Also ask how a hospice enrollment will change your financial arrangements with the facility.

In rare cases, hospice patients may need “continuous” care in the home, for instance if symptoms get out of control or when they are very near death. This level of care may not be needed but should be available.

► **Do you have your own hospice unit for inpatient care? Under what circumstances are patients admitted to the unit? What are your room and board rates? When are these charges not covered by Medicare or my private insurance?**

Most inpatient hospice residence rooms are reserved for patients with intensive care needs — out-of-control symptoms, pain crisis, or “active dying.” However, some residences admit routine level of care patients who do not have caregivers at home or nearby. Make sure you understand how the hospice operates its facility, what it charges, and when.

► **Is everything covered by Medicare/my insurance? What services are not?**

Items not covered might include some drug copays; non-medical caregiving/housekeeping; one-on-one grief counseling; and care for conditions or events not related to the terminal illness (*e.g.*, broken bones or infectious illness).

► **How can we pay for care if my family member or I are not on Medicare?**

The hospice social worker can review your private insurance and determine what your benefits cover.

If you lack insurance, payment assistance might be available from Medicaid, veteran benefits, or other programs for uninsured patients. The hospice should provide every assistance to address your financial questions.

► **How do you respond to needs after hours or on weekends or holidays?**

Be sure the hospice has adequate coverage from its own staff for care in these situations. At a minimum, an after-hours phone number should be available and, if needed, a visit from a nurse.

► **What is your average length of stay for patients and rate of live discharge?**

Significant deviations from national averages (currently 68 days mean/23 days median for length of stay and 15 percent live discharge) might be cause for concern. *All other factors being equal*, a hospice that operates closer to the norm may be a better choice.

► **Have you had any recent complaints or patient care deficiencies?**

This information is publicly available from the state health department website. It's worthwhile to scan the information on the website first and then ask about particular instances that concern you. The hospice may not be able to discuss specifics due to patient privacy limitations, but they should confidently communicate that they take all complaints and deficiencies seriously and ensure that any problems are addressed and corrected. Defensiveness, evasion, denial, or referral to legal representatives should be red flags.

► **What kind of support is available to the family/caregiver?**

At a minimum, this should include education and emotional/spiritual support throughout the hospice patient's stay; assistance with practical, financial, and logistical challenges; visits from a volunteer; and bereavement counseling.

► **What kind of bereavement/grief support or counseling do you offer?**

At a minimum, this should include regular contact from the hospice following the death of the patient for 13 months by phone or mail. More robust services might include support groups, grief education sessions, one-on-one counseling, retreats for adults or camps for children and teens, regular memorial services, and so on.

Hospice is a wonderful service to persons with end-stage illness and their families, but it's not for everyone. Some people don't "qualify" for hospice care, and some just aren't ready or never get the opportunity to shift from curative treatment to hospice care. Fortunately, there is an alternative: palliative care.

Medical Aid in Dying

The Colorado End-of-Life Options Act was passed in November 2016 by 64 percent of Colorado voters. The eligibility requirements to become qualified to use the law are similar to those in 11 jurisdictions that have instituted Medical Aid in Dying (MAID) laws to date. There are slight variations in how the law is operationalized in each state. In Colorado, a resident adult with mental capacity must be certified as terminally ill by two physicians. The person then must make two oral requests at least 15 days apart and must also submit one written, witnessed request.

Comprehensive measures are legally required to educate the person about other alternative or additional treatment opportunities, such as palliative care and hospice. The person must understand clearly what their prognosis is and must understand both the risks and results

of taking the medication. They must also be able to self-administer the medication, which can be taken orally, by feeding tube, or rectally.

In 2022, it was reported that 75 percent of MAID patients in Colorado were enrolled in hospices¹⁹. Because of the kind of care that using MAID requires, it is highly suggested that patients pursue hospice care. The MAID certification for terminal illness parallels the hospice requirement of a 6-months or less prognosis.

Developmental issues in Colorado continue to be like those in other states: Although physicians are immune from prosecution or professional disciplinary action, many are reluctant to engage in a practice as controversial as this. Although it is per se illegal to forbid a physician to prescribe the medication, many still fear conflict or retribution within their organizations or from their employers. Patient abandonment is a significant concern for medical providers — am I abandoning my patient if I help them to end their life, or am I abandoning my patient if I refuse to support their desire to use MAID?

At this time, locating an attending physician or the second (consulting) physician who will assist their process has fallen primarily to patients, families, and advocates. The American Clinicians Academy on Medical Aid in Dying²⁰ has a referral tool where interested people can ask for referrals to physicians near them. There is no charge for either of these services, and there is no guarantee that the connections will result in the implementation of MAID.

There are several health systems in Colorado that are currently in full compliance with the law and provide complete supportive services to their patients (including UC Health, Kaiser Permanente, Denver Health, and Boulder Community Health). Services may include sophisticated education to help in navigating the process, obtaining the medication, and supporting the patient and family during ingestion and afterward. They are also more likely to connect with a consulting physician, and a compounding pharmacy that can fill the prescription.

Colorado hospices have developed policies ranging from refusal to engage in dialogue with patients at all about MAID to “engaged neutrality,” which means providing full support for patients but refusal to act as prescribing physicians. Hospice policies vary on issues such as admission requirements for MAID patients and on their approaches to staff presence in the house at the time of ingestion.

The Colorado Department of Public Health and Environment website includes information about the Colorado End-of-Life Options Act and an annual statistical report.²¹ According to the 2023 report, 316 Coloradans were prescribed aid-in-dying medication in 2022, and 220 prescriptions were written in 2021. A controversial issue in Colorado is the lack of comparative and robust publicly available reporting requirements.²²

¹⁹ Campbell EG, Kini V, Ressalam J, Mosley BS, Bolcic-Jankovic D, Lum HD, Kessler ER, DeCamp M. Physicians’ Attitudes and Experiences with Medical Aid in Dying in Colorado: a “Hidden Population” Survey. *J Gen Intern Med.* 2022 Oct;37(13):3310-3317. doi: 10.1007/s11606-021-07300-8. Epub 2022 Jan 11. PMID: 35018562; PMCID: PMC8751472.

²⁰ American Clinicians Academy on Medical Aid in Dying, <https://www.acamaid.org/>.

²¹ Colorado Department of Public Health & Environment, Medical Aid in Dying, www.colorado.gov/pacific/cdphe/medical-aid-dying.

²² J.T. Abbott et al., “Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-in-Dying,” *Health Affairs* (Nov. 11, 2017), www.healthaffairs.org/doi/10.1377/hblog.20171109.33370/full.

For the first time since voter approval in 2016, revisions to the Colorado End-of-Life Options Act are being considered at the time of writing in 2024. Senate Bill 24-068 proposes three clinical changes to the existing Colorado End-of-Life Options Act law:

1. Providing an advanced practice registered nurse with the same authority to evaluate an individual and prescribe medication as a physician.
2. Removing the requirement that an individual must be a resident of the state to access end-of-life options (currently the residency requirement has been amended back into the bill).
3. Reducing the waiting period between oral requests from 15 days to 48 hours and allowing attending providers to waive the mandatory waiting period if the patient is unlikely to survive more than 48 hours and meets all other qualifications (currently the waiting period has been amended from 15 days to 7 days, unless the patient is unlikely to survive more than 48 hours).

These changes are under consideration and the final outcome will not be known prior to publication of the *Colorado Senior Law Handbook, 2024 Edition*.

22-6. What Is Palliative Care?

Palliative (PAH-lee-uh-tiv) care is a relatively new kid on the block of American health care. It began growing rapidly in the mid-1990s and was granted official “sub-specialty” status by the American Board of Medical Specialties in 2006. Like hospice care, palliative care focuses on comfort and quality of life; aggressive treatment of distressing symptoms; and emotional, social, and spiritual support for patients and families. It involves a team of professionals addressing the needs and concerns of the whole person and family members.

Unlike hospice, palliative care does not require a doctor’s certification of terminal disease or life expectancy. It can be offered along with curative treatment, and it is not limited to “end-stage” or “terminal” illness. Conditions that can benefit greatly from palliative care include Alzheimer’s disease and other dementias; heart, lung, kidney, and liver diseases; chronic cancer; multiple sclerosis; cystic fibrosis; Parkinson’s and Huntington’s diseases; traumatic brain injury; frailty of old age; and other chronic conditions.

Other big differences between hospice and palliative care are that, right now, there is limited insurance coverage for palliative care services and only very generally accepted standards and regulations governing them. Both of these issues are discussed below.

22-7. How Can I Get Palliative Care?

Palliative care can begin at any point in the course of a serious illness and be provided side-by-side with treatment oriented toward cure. Right now, it is most commonly used when a person’s illness has become advanced, not curable, and difficult to manage, but is not yet at the terminal stage, such as those listed above.

If you think you might benefit from palliative care, you should first talk to your primary physician, the hospitalist (the doctor overseeing your care in a hospital), the nursing home medical director, or the specialist treating your illness to discuss what services might be helpful

and available. A list of Colorado hospices and hospitals offering palliative care is included as Exhibit 22A to this chapter.

22-8. How Does Palliative Care Work?

Palliative care is a rapidly growing field: Consistent models of care, standards, or even criteria defining in detail what it is and is not and what it does and does not provide have not yet been consistently adopted. As a result, there can be big variations in palliative care services and quality. In 2011, the Colorado Center for Hospice and Palliative Care, along with the Center to Improve Value in Health Care and Life Quality Institute, developed a set of guidelines to assist state surveyors in evaluating whether so-called “palliative care” services really offer what they should in the way that they should.

In January 2014, Colorado became the first state in the nation to adopt a regulatory definition and standards for palliative care.²³ The definition and standards (see box, below), approved by the Colorado Board of Health, went into effect in March 2014, and are applicable to any health care facility or setting offering “palliative care,” “comfort care,” “supportive care,” or other substantially similar services. The Colorado Department of Public Health & Environment has developed a webpage specifically for palliative care information, including a comprehensive survey of Colorado palliative care providers in 2020.²⁴

Palliative Care Definition and Standards Approved by the Colorado Board of Health for Inclusion in the Colorado Health Care Facilities Regulations as of March 2014

Definition:

“Palliative care” means specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family. Palliative care is provided by a team of physicians, nurses, and other specialists who work with a patient’s other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment. Unless otherwise indicated, the term “palliative care” is synonymous with the terms “comfort care,” “supportive care,” and similar designations.

Standards:

If palliative care is provided within a licensed health care entity, the licensee shall have written policies and procedures for the comprehensive delivery of these services. For each patient receiving palliative care, there shall be documentation in the plan of care regarding evaluation of the patient and what services will be provided. The licensee’s policies and procedures shall address the following elements of palliative care and how they will be provided and documented:

- 1) Assessment and management of the patient’s pain and other distressing symptoms; and

²³ For additional detail, refer the provider to Sections 2.2.12 and 3.3 of the Colorado Code of Regulations for health care facilities, “Chapter II General Licensure Standards.”

²⁴ Colorado Department of Public Health & Environment, Palliative Care, <https://cdphe.colorado.gov/palliative-care>.

- 2) Goals of care and advance care planning; and
- 3) Provision of, or access to, services to meet the psychosocial and spiritual needs of the patient and family; and
- 4) Provision of, or access to, a support system to help the family cope during the patient's illnesses; and
- 5) As indicated, the need for bereavement support for families by providing resources or referral.

When you contact a provider for palliative care, be sure to get a clear and thorough explanation of just what is being offered. At its most basic, a palliative care service provides consultation with a specially trained doctor or advance practice nurse to develop a plan of care to enhance comfort and quality of life rather than cure, and to address any areas of distress. More developed programs involve consultation with a full palliative care team and perhaps some limited follow up with or ongoing care of the person at home or in a health care facility.

In general, palliative care programs come in four styles from four different provider types: hospitals, hospice agencies, nursing homes, and most recently, specialty outpatient clinics.

Hospital-Based Palliative Care

About 28 hospitals around the state offer palliative care services of some kind, though the scope of service may vary. A list of Colorado hospitals reporting palliative care services can be found in Exhibit 22A. Typically, palliative care in the hospital setting is offered to patients with serious, advanced illness for which they are receiving continued curative treatment but are “wiped out” by the side effects, or the treatments are not working as well, fewer options are available, and a shift in goals of care might be warranted. A consultation team comprises a specially trained doctor or advance practice nurse — and, ideally, a social worker and chaplain — who identify physical and psychosocial-spiritual suffering that can be eased by palliative treatment. Beyond this, they help clarify the patient's goals for care and work with the patient's other doctors to develop a plan that matches or meets those goals. In most hospital-based programs, however, there is no ongoing follow-up after the patient is discharged.

“Pre-Hospice” Palliative Care

Another type of palliative care program, often called “pre-hospice” or “transition,” is offered by hospice agencies. About 29 hospices across Colorado offer palliative care services. A list of Colorado hospices providing palliative care services can be found in Exhibit 22A. In these programs, you can receive a palliative care consultation and a limited amount of follow-up without enrolling in hospice. Some of these programs are led by nurse practitioners, some by social workers. The programs focus on pain and symptom management and clarifying goals of care. They provide a real option for persons who are not quite ready for hospice from the standpoint of their personal goals or the progress of their illness.

Palliative Care in Long-Term Care

For better or for worse, many of us will likely spend some part of our final days in nursing facilities — for rehabilitation, skilled nursing, or long-term residence. Most elders who enter nursing homes for long-term residence die within two to three years of admission, and they

suffer from an average of five concurrent chronic illnesses. Typically, nursing homes have worked closely with hospices to provide high-quality palliative and end-of-life care.

Note: The Center for Improving Value in Health Care (CIVHC), in collaboration with other organizations, has developed a set of “Best Practice” guidelines for palliative care in the long-term care setting. If your nursing home is not yet following these guidelines, they are available from CIVHC (www.civhc.org; (720) 583-2095).

Palliative Care in Specialty Outpatient Clinics

For the first time ever, a 2020 study of palliative care across Colorado²⁵ identified one non-hospital, non-hospice palliative care provider. This provider, Kaiser Permanente, provides palliative care in a specialty outpatient clinic setting. Additionally, two other providers in similar settings were identified as “emerging palliative care providers”, meaning they didn’t quite meet the study definition of palliative care provider but were close. Exhibit 22A identifies and details contact information for all Colorado palliative care providers, including emerging palliative care providers.

Even more than in the hospice or hospital setting, palliative care programs in long-term care facilities are subject to wide variation. In some cases, palliative or “comfort” care here simply means pain and symptom management performed under the guidance of a doctor who may or may not be specifically trained in palliative or end-of-life care. In other cases, it is very high-quality and full-spectrum end-of-life care up to and including the hospice phase. As of March 2014, any nursing facility offering palliative or “comfort care” must meet the new standards. If you or a loved one reside in a nursing home and are a good candidate for palliative care, be sure you get a thorough explanation of just what this means at that facility and be sure your needs will be appropriately addressed.

Caution: Some nursing homes will offer what they call a “comfort-care benefit.” **There is no specific benefit offered by Medicare or Medicaid for “comfort care”!** If the nursing facility offers “comfort care” for you or your loved one, instead of arranging a hospice or palliative care consultation, you should ask very probing questions about exactly how their “comfort care” will be different from their standard care, who will be supervising it, what the plan of care will entail, whether it will meet the new standards, and why hospice or palliative care is not the best course. If comfort care is recommended, it is best to ensure involvement from a hospice or specifically trained palliative care provider.

22-9. How Is Palliative Care Paid For?

The other big difference between hospice and palliative care is that there is no Medicare Palliative Care Benefit. At this writing, Medicare will cover one visit from a hospice or hospital-based palliative care doctor, nurse practitioner (NP), and sometimes a licensed clinical social worker for palliative care consultation. Additional visits may be billable by physicians and NPs under some circumstances, but visits by social workers are rarely covered, and no visits

²⁵ Colorado Department of Public Health & Environment, Palliative Care in Colorado: Trends, Gaps, and Opportunities to Improve Care, <https://drive.google.com/file/d/1cm2OivJ3GKCBYGqCKK9u-5eJ0V8pf5NS/view>.

by chaplains are reimbursed. Some private insurers and managed care organizations (notably, Kaiser Permanente) are adding palliative care benefits.

Hospice agencies offering palliative care programs often do so at their own loss, out of charitable monies, or through private-pay arrangements. The Veterans Health Administration offers palliative care services at no extra charge to qualified persons. Palliative care can also be obtained through a few private practice doctors, advanced practice nurses, and nurse practitioners on a fee-for-service basis. When you are offered or evaluating palliative care services, be sure to ask about payment.

22-10. How Can I Find Palliative Care?

First, ask your physician. You can also ask your hospital or local hospice agencies about their palliative care programs. For a list of Colorado hospitals, hospices, and others offering palliative care services in Colorado, see Exhibit 22A. An interactive map of current palliative care providers can be found on the Center for Improving Value in Health Care website.²⁶ For services and programs outside Colorado, you can visit the National Hospice Locator,²⁷ the National Hospice and Palliative Care Organization,²⁸ or the American Academy of Hospice and Palliative Medicine.²⁹ Phone numbers for these organizations may be found at Appendix A: Resources, Chapter 22.

22-11. How Can I Learn More?

If you would like to know more about hospice or palliative care, most hospice agencies are happy to answer your questions. The Center to Advance Palliative Care offers consumer-oriented information and resources on its website.³⁰

For more resources and information surrounding hospice and palliative care see Appendix A: Resources, Chapter 22.

22-12. Conclusion

Hospice and palliative care are relative newcomers to the health care system, but they are actually new and improved forms of what medicine and health care has been about for thousands of years: caring for the sick, comforting the hurt, and supporting those who love them. Their shared goal is to help all people live well at the end of life and never suffer needlessly.

*Excerpted and adapted with permission from *How Hospice Can Save Your Life: A Guide to End-of-Life Care Options in Colorado*, by Jennifer Ballentine, forthcoming. Copyright © Jennifer Ballentine, 2008–2017.

²⁶ Center for Improving Value in Health Care, Palliative Care Map and Report, <https://www.civhc.org/programs-and-services/palliative-care/palliative-care-in-colorado/>.

²⁷ Hospice Analytics' National Hospice Locator, www.NationalHospiceLocator.com.

²⁸ National Hospice and Palliative Care Organization, www.nhpc.org.

²⁹ American Academy of Hospice and Palliative Medicine, www.aahpm.org.

³⁰ Center to Advance Palliative Care, www.getpalliativecare.org.

Exhibit 22A. Hospitals, Hospice Agencies, and Others Offering Palliative Care

Hospitals, Hospice Agencies, and Others Offering Palliative Care (as distinct from hospice services)*

Geography	Hospitals Offering Palliative Care	Hospice Agencies and Others Offering Palliative Care
Denver Metro	<ul style="list-style-type: none"> • Centura Castle Rock Adventist Hospital*, 303-738-2605 • Centura Littleton Adventist Hospital, 303-738-2605 • Centura Parker Adventist Hospital, 303-269-2452 • Centura Porter Adventist Hospital, 303-778-5699 • Centura St. Anthony Hospital (Lakewood), 720-321-1590 • Centura St. Anthony's North Health Campus (Westminster), 720-627-0036 • Children's Hospital Anschutz, 303-204-0912 • Denver Health*, 303-436-6000 • Lutheran Medical Center Hospital (Wheat Ridge), 303-425-8000 • Medical Center of Aurora, 303-944-9500 • National Jewish Health*, 303-475-2841 • North Suburban Medical Center (Thornton), 303-450-3551 • Presbyterian St. Luke's Medical Center, 303-944-9500 • Rocky Mountain Hospital for Children • Saint Joseph Hospital, 303-746-9197 • Sky Ridge Medical Center (Lone Tree), 303-263-3647 • Swedish Medical Center, 303-788-4475 • UCH University of Colorado Anschutz Hospital, 720-848-8530 • VA Eastern Colorado Healthcare System, 303-907-7132 	<ul style="list-style-type: none"> • Agape Hospice & Palliative Care (Greenwood Village), 720-482-1988 • Aspire Health Care^*, 303-692-2507 • Berkley Palliative Care & Hospice (Aurora), 303-758-2000 • Bridges Hospice & Palliative Care (Wheat Ridge), 720-900-3505 • Colorado Palliative Care & Hospice – Denver, 303-727-5709 • Colorado VNA Hospice & Palliative Care (Arvada), 303-698-6386 • Compassus – Denver, 720-808-5373 • Complete Hospice & Palliative Care of Denver, 720-425-3135 • Divine Hospice & Palliative Care, 303-357-2540 • Hospice Care of the Rockies (Cherry Hills Village), 303-284-6846 • Kaiser Permanente Palliative Care Clinics^, 720-518-6158 • Lutheran Medical Center Hospice & Palliative Care (Wheat Ridge), 303-425-8000 • Mission Healthcare Services* (Centennial), 303-708-1122 • Mount Evans Hospice & Palliative Care (Evergreen), 303-674-6400 • Namaste Home Health & Hospice, 720-532-3686 • Porter Hospice* (Greenwood Village), 303-561-5000 • Suncrest Hospice of Colorado (Greenwood Village), 720-941-5580 • The Denver Hospice, 303-321-2929 x6229 • The Holding Group^*, 720-295-1844
Northern Colorado (e.g., Boulder, Greeley, Fort Collins)	<ul style="list-style-type: none"> • Centura Longmont United Hospital, 303-485-4391 • Foothills Hospital (formerly Boulder Community Hospital), 303-415-7543 • Good Samaritan Medical Center (Lafayette), 303-689-5236 • Northern Colorado Medical Center (Greeley), 970-810-4288 • UCH Medical Center of the Rockies (Loveland), 970-495-8369 	<ul style="list-style-type: none"> • Front Range Hospice & Palliative Care (Frederick), 303-957-3101 • Halcyon Hospice & Palliative Care (Mead), 303-329-0870 x301 • Pathways Hospice & Palliative Care, 970-889-0272 • Trailwinds Hospice & Palliative Care (Boulder), 303-442-5683 • TRU Community Care (Lafayette), 303-449-7740
Western Colorado (e.g., Grand Junction, Glenwood Springs, Durango)	<ul style="list-style-type: none"> • Aspen Valley Hospital, 970-544-1147 • Centura Mercy Regional Medical Center (Durango), 970-764-3534 • St. Mary's Hospital & Medical Center, 970-298-2288 • VA Western Colorado Healthcare System, 970-242-0731 x2737 • Valley View Hospital, 970-745-6535 	<ul style="list-style-type: none"> • HopeWest, 970-683-4902 • Hospice of Mercy – Durango, 970-764-3534 • Hospice of the Valley (Glenwood Springs), 970-930-6008
Colorado Springs	<ul style="list-style-type: none"> • Centura Penrose St. Francis, 719-776-7148 • UCH Memorial Hospital Central, 719-365-2567 	<ul style="list-style-type: none"> • Abode Hospice & Home Health of Colorado – Colorado Springs, 719-505-2057 • Bridges Hospice & Palliative Care – Colorado Springs, 719-596-5001 • Colorado Palliative Care & Hospice – Colorado Springs, 719-419-5595 • Compassus – Colorado Springs, 719-226-0091 • Interim Healthcare Hospice & Palliative Care, 719-314-4868 • Pikes Peak Hospice & Palliative Care, 719-457-8147
Southern Colorado (e.g., Pueblo)	<ul style="list-style-type: none"> • Parkview Medical Center*, 719-595-7704 	<ul style="list-style-type: none"> • Arkansas Valley Hospice (La Junta), 719-384-8827 • Fremont Regional Hospice (Canon City), 719-275-4315 • Frontier Hospice (Pueblo), 719-544-5891 x121 • Hospice Del Valle (Alamosa), 719-589-9019

		<ul style="list-style-type: none">• Lamar Area Hospice Association, 719-336-2100• Mt Rose Health Center Palliative Care & Hospice (Trinidad), 719-846-8478• Sangre de Cristo Hospice & Palliative Care (Pueblo), 719-251-8111
<p>*Palliative care programs were considered “emerging” for the purposes of this survey if any of the following criteria existed:</p> <ol style="list-style-type: none">1. Entity unable to capture patients served or consults;2. Entity unable to respond to the survey in the requested timeline;3. Entity did not see patients during the captured timeframe; or4. Entity did not meet the state’s regulatory definition of palliative care <p>^ Other (non-hospital and non-hospice) palliative care provider.</p> <p>Adapted with permission from <i>Palliative Care in Colorado: Trends, Gaps, and Opportunities to Improve Care in Colorado</i>, Appendix 3: 2020 Directory of Colorado Palliative Care Providers; Colorado Department of Public Health & Environment (https://cdphe.colorado.gov/palliative-care), based on research provided by Hospice Analytics (www.hospiceanalytics.com).</p>		